FOOTHILL-DE ANZA
Community College District

EMPLOYEE BENEFIT BOOKLET

Preferred Provider Organization (PPO) Medical Plan
Prescription Drugs

UnitedHealthcare **CHOICE PLUS** Health Plan

Effective: July 1, 2011

Group Number: 708611

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A UnitedHealth Group Company

PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Out-of-Pocket Maximum and Lifetime Maximum Benefit.

Medical Plan (Preferred Provider Organization)		
	Network Provider	Non-Network Provider
Lifetime Maximum Payment Limits ■ Hospice Care……..……$10,000		
Physician Office Copay Amount	$25 per visit	None
Specialist Office Copay Amount	$30 per visit	None
Covered Charges will be payable at 100% after the Copay amount. The Copay amount will not count toward satisfaction of the Out-of-Pocket and will continue to apply after the Out-of-Pocket Maximum has been reached.		
Emergency Room Copay Amount	$100 per visit*	$100 per visit*
*Copay waived if admitted.		
Inpatient Hospital Confinement Copay Amount	$100 per confinement	None
Annual Deductibles		
■ Per Person	$350	$700
■ Per Family	$1,050	$2,100
Out-of-Pocket Maximums		
■ Per Person	$1,000	$3,000
■ Per Family	$3,000	$9,000
If the amount you pay for Eligible Expenses in any one calendar year reaches the Out-of-Pocket Maximum shown above, subsequent covered medical Benefits will be payable at 100% for the remainder of the calendar year (except as described above for Copay amounts). The Annual Deductible and Copays do not apply to the Out-of-Pocket Maximum.		

This table provides an overview of the Plan's coverage levels.

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Acupuncture/Acupressure Services (Copay is per visit) Limited to a combined 30 visits per calendar year with Chiropractic visits.	100% after you pay a $25 Copay	70% after you meet the Deductible
Allergy Injections/Serum	100% after you pay a $30 Copay	70% after you meet the Deductible
Ambulance Services - Emergency Only		
Ground	90% after you meet the Deductible	90% after you meet the Deductible
Air	90% after you meet the Deductible	90% after you meet the Deductible
Ambulatory Surgical Center	90% after you meet the Deductible	70% after you meet the Deductible
Birthing Centers	90% after you meet the Deductible	70% after you meet the Deductible
Chiropractic Services (Copay is per visit) Limited to a combined 30 visits per Calendar Year with Acupuncture/Acupressure	100% after you pay a $25 Copay	70% after you meet the Deductible
Cochlear Implants		
Physician's Office/Clinic (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
(Cochlear Implant device combined with Hearing Aid benefit not to exceed $5,000 per calendar year.)		

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Congenital Heart Disease Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Dental Services - Accidental Only (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Diagnostic X-ray and Lab - Includes mammograms		
Outpatient Hospital	90% after you meet the Deductible	70% after you meet the Deductible
Physician's Office/Clinic (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
Stand-alone diagnostic X-ray and lab facility	90% after you meet the Deductible	70% after you meet the Deductible
Durable Medical Equipment (DME)	90% after you meet the Deductible	70% after you meet the Deductible
Emergency Room True Emergency *Copay waived if admitted	90% after you pay a $100 Copay*	90% after you pay a $100 Copay*
Non-Emergency	90% after you pay a $100 Copay plus Deductible	70% after you pay a $100 Copay plus Deductible
Hearing Aids Limited to $5,000 annually. Includes hearing aids and fittings. Batteries not included in annual maximum. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.	50% after you meet the Deductible	50% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Home Health Care Limited to 60 visits per calendar year with four hours equaling one visit.	90% after you meet the Deductible	70% after you meet the Deductible
Hospice Care Limited to $10,000 maximum lifetime benefit for each Covered Person.	90% after you meet the Deductible	70% after you meet the Deductible
Hospital - Inpatient Stay	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Infertility Services - Diagnostic Only		
Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Outpatient services received at a Hospital or Alternate Facility	90% after you meet the Deductible	70% after you meet the Deductible
Injections in a Physician's Office		
Physician's Office Services (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
Outpatient services received at a Hospital or Alternate Facility	90% after you meet the Deductible	70% after you meet the Deductible
Maternity Services		
Prenatal care (No Copay applies for prenatal visits after the first visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
Delivery, post-natal care and any related complications		
- Physician's Office Services (Copay is per visit)	100% after you pay a $25 Copay	70% after you meet the Deductible
- Hospital - Inpatient Stay	$100 Copay then 90% after you meet	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
	the Deductible	
- Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
Mental Health		
United Behavioral Health EAP: Your employer offers an Employee Assistance Program through United Behavioral Health EAP. This program enables you and your covered Dependents to receive up to five (5) outpatient visits payable at 100%. It is recommended that, before seeking treatment or service elsewhere, you utilize this program first, then any additional treatment or services will be payable as described below.		
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders		
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Substance Use Disorders		
Inpatient Chemical Dependency Counselor, Certified Alcohol Counselor, and Certified Drug and Alcohol Counselor	90% after you meet the Deductible	70% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Inpatient Service	90% after you meet the Deductible	70% after you meet the Deductible
Partial Hospitalization (Copay is per admission)	$100 Copay then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Services	100% after you pay a $25 Copay	70% after you meet the Deductible
Nutritional Counseling (Copay is per visit) Limited to 10 visits per calendar year in a Hospital based program.	100% after you pay a $30 Copay	70% after you meet the Deductible
Obesity Surgery		
Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
Hospital - Inpatient Stay	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services	90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Hospital Services	90% after you meet the Deductible	70% after you meet the Deductible
Outpatient Surgery, Diagnostic and	90% after you meet	70% after you meet

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Therapeutic Services	the Deductible	the Deductible
Physical, Occupational, Cardiac, Pulmonary & Speech Therapy Services (Rehabilitation)		
Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission)	$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Physician Hospital Services	90% after you meet the Deductible	70% after you meet the Deductible
Physician's Office Services (Copay is per visit)		
Primary	100% after you pay a $25 Copay	70% after you meet the Deductible
Specialist	100% after you pay a $30 Copay	70% after you meet the Deductible
Preventive Care/Routine Health Screenings, including Well Baby Care	100%	70% after you meet the Deductible
Private Duty Nursing – Outpatient Services are limited to $25,000 per year	90% after you meet the Deductible	70% after you meet the Deductible
Professional Fees for Surgical and Medical Services	90% after you meet the Deductible	70% after you meet the Deductible
Prosthetic Devices Limited to $10,000 per Calendar Year	90% after you meet the Deductible	70% after you meet the Deductible
Second Opinion Consultation Charges		
Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay	70% after you meet the Deductible
Professional Fees (inpatient setting)	90% after you meet the Deductible	70% after you meet the Deductible

Covered Health Services[1]	Payable by the Plan:	
	Network Percentage of Eligible Expenses	**Non-Network Percentage of Eligible Expenses**
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	\$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Temporomandibular Joint Dysfunction (TMJ)		
Physician's Office Services (Copay is per visit)	100% after you pay a \$30 Copay	70% after you meet the Deductible
Hospital - Inpatient Stay (Copay is per admission) Includes surgery to correct TMJ and non-surgical treatment of TMJ. Non-surgical treatment does not include orthodontia.	\$100 Copay and then 90% after you meet the Deductible	70% after you meet the Deductible
Transplantation Services (If services rendered by a Designated United Resource Networks Facility)		
Hospital - Inpatient Stay (Copay is per admission)	\$100 Copay and then 90% after you meet the Deductible	Not covered
Urgent Care Center Services (Copay is per visit)	100% after you pay a \$30 Copay	70% after you meet the Deductible
All Other Covered Charges	90% after you meet the Deductible	70% after you meet the Deductible

[1]In general, your Network Provider must notify Care Coordination℠, as described in Section 4, of the Plan Document before you receive certain Covered Health Services. There are some network Benefits, however, for which you are responsible for notifying Care Coordination℠. See your Plan Document, Section 6, *Additional Coverage Details* for further information.

PRESCRIPTION DRUGS

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services[1]	**Copays**	
	Network	**Non-Network**
Retail - up to a 30-day supply		
Tier 1	$10 Copay	$10 Copay
Tier 2	$25 Copay	$25 Copay
Tier 3	$50 Copay	$50 Copay
Mail Order - up to a 90-day supply		
Tier 1	$20 Copay	$20 Copay
Tier 2	$50 Copay	$50 Copay
Tier 3	$100 Copay	$100 Copay
You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in the Plan Document for details. Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, you must pay the difference between the Generic Drug price and the Brand Name Drug price, in addition to the Generic Drug Copay amount. However, if the Physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as written" on the prescription, the Brand Name Drug Copay amount in addition to any ancillary charges will apply. If there is no generic equivalent available and a Brand Name Drug is dispensed, the Brand Name Drug Copay will apply.		

Rx Mail Order Out-of-Pocket Maximum

The maximum per calendar year that an individual Covered Person will have to pay for mail order prescription Copayments is $1,000.